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## AIDS symposium

# Psychosocial ethical aspects of AIDS

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### Author's abstract

*The psychosocial morbidity associated with HIV infection and responses to such infection may exceed morbidity associated with medical sequelae of such infection. This paper argues that negative judgements on those with HIV infection or in groups associated with such infection will cause avoidable psychological and social distress. Moral judgements made regarding HIV infection may also harm the common good by promoting conditions which may increase the spread of HIV infection. This paper examines these two lines of argument with regard to the ethical aspects of psychological bases of health care, clinical contact, public perceptions of AIDS and the comparative perspective. It is concluded that the psychosocial aspects of HIV infection impose ethical psychological, as well as medical, obligations to reduce harm and prevent the spread of infection.*

In the Western world, psychosocial issues surrounding the Acquired Immune Deficiency Syndrome (AIDS) probably create more controversy, and give rise to greater psychosocial morbidity, than the medical sequelae of infection by Human Immunodeficiency Virus (HIV). As with other sexually transmissible diseases (STDs), psychosocial aspects of AIDS demand special attention. In 1981, Darrow (1) commented that while most individuals saw STDs as a medical problem with some social aspects, he saw STDs as a social problem with some medical aspects. Hart (2) has also noted that psychological factors must be considered as important as social or medical ones: 'STDs are a behavioural problem, control of which requires a primary focus on the personality of the individual'. Ethical considerations of such psychological and social aspects of AIDS raise a number of critical issues which deserve exploration: this discussion is limited to the situation in the Western world.

To date, ethical issues in AIDS have been discussed primarily in terms of medical treatment (3) and

research (4). Murray (3) argues that AIDS has raised issues of medical ethics because the root of most dilemmas in medical ethics is the power conferred by our abilities to cure and control: in the case of AIDS, almost the opposite is true, since it is our powerlessness which creates the most difficult moral problems. At a psychological level, the ethical issues which arise are much more complex than this.

Because AIDS involves sexual behaviour, and particularly a form of sexual behaviour which characterises a stigmatised minority group, it raises other much more fundamental issues. Indeed, this may be illustrated by noting that in a study carried out in 1970 (5), a majority of physicians indicated that knowing a patient was homosexual would adversely affect their medical management. In 1985, similar research (6) found that two-thirds of physicians and nurses who had treated AIDS patients believed that AIDS patients received inferior care compared with other patients, and 12 per cent of nurses and 3 per cent of physicians felt that homosexual men with AIDS were 'getting what they deserve'. Such findings clearly alert us to the fact that the ethical dilemmas relate not primarily to the medical aspects (for example HIV is not as easily transmissible as many other infectious diseases) but to the issues of dealing with a pathogen which in the West is predominantly infecting minority groups subject to stigmatisation (homosexual men, intravenous drug users, prostitutes, Haitians). Since, as Osborn (7) has already noted, preventive medicine is at present the only solution to limiting the spread of HIV, and since prevention is entirely behavioural in this context, psychological and ethical aspects of AIDS need to be considered.

This paper has two lines of argument. The first is that ethical judgements, and behaviour resulting from such ethical judgements concerning HIV infection and related diseases can result in adverse psychological effects on people who are the subjects of such judgements, which is a bad thing in itself. The second is that negative ethical judgements about HIV and associated infections can actually harm the common good by increasing rather than reducing the spread of HIV within the community. From the perspective of medical ethics, and in particular medical ethics in relation to preventive medicine, there are two moral

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### Key words

AIDS; psychosocial issues; AIDS: ethics; AIDS: homosexual; AIDS: prevention; AIDS: counselling.

claims being argued for:

- i) That our obligation to our patients and to those who are suffering from infections and diseases requires us not to make any adverse moral judgements that will harm them, and not to behave in ways based on those adverse moral judgements that will harm them.
- ii) Insofar as we are concerned in minimising the spread of HIV infection within the community, we should also avoid adverse moral judgements and behaviour based on such judgements, for only by doing so will we minimise such spread.

Within each section, these two lines of argument will be demarcated.

### Ethical psychological bases of health care

First, the assumptions on which determinations of what is ethical are based must be raised. I assume that there are no absolute standards of right or wrong (8), so that determinations of what is 'ethical' need to be based upon specific and agreed objectives. Five of these can be identified in this context:

- i) Minimisation of the spread of HIV infection in the general community and in the different groups most affected.
- ii) Maintenance of an approach to AIDS consistent with our approach to other infectious diseases and public health problems.
- iii) Avoidance of social and psychological damage to those carrying the virus or in the groups most affected.
- iv) Minimisation of damage to civil liberties, and to equality of the value of human lives.
- v) Calming irrational and harmful public reaction and correcting misinformation, thus reducing social and psychological damage both to those at minimal risk of infection, and to those groups most affected by the infection.

Apparently positive objectives with regard to AIDS may also be couched in psychologically negative terms, and it is important to note objectives such as a reduction in the prevalence of homosexual acts and further stigmatising homosexuality as a means of reducing spread would be inappropriate from a psychological point of view. From a public health perspective, since there is some evidence that decriminalisation of homosexual acts may be associated with lower STD rates in homosexual men (9), further stigmatisation or recriminalisation would probably increase the spread of AIDS. This example of an objective couched in negative terms illustrates that while measures which met this objective might be considered 'ethical', they could be considered unethical from a psychosocial or public mental health perspective. The precept *primum non nocere* should apply as much to psychological and social harm as to harm to physical health.

While there are no universal, extra-human standards

of right or wrong, there are a number of very general principles of human rights and medical ethics regarding all human beings, universally accepted by most member states of the United Nations and the medical profession. Referring to these ethical standards, already generally accepted, gives us a firmer basis, stronger moral leverage and a greater accuracy in developing ethical principles pertaining to AIDS (since any application of ethics in a particular situation ought to be logically derived from a set of general ethical maxims).

The problem, of course, is that the more general an ethical principle is (and the stronger its moral power) the greater also the complexity of interpretation and ambiguity. Therefore, where a generally accepted interpretation of a particular case does not exist, we must explicate the interpretation.

There are, however, a number of general social and medical ethical principles that we could use as our basis. *The United Nations Covenant on Civil and Political Rights* sets out the general ethical principle that:

'All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status' (Article 26).

The European Court of Human Rights found in the Dudgeon case (10) that these principles are applicable to homosexuals, which subsequently led to the decriminalisation of homosexuality in Northern Ireland.

*The Declaration of Helsinki*, adopted by the 18th World Medical Assembly in 1964 is the most commonly accepted set of ethical guidelines for medical research including research involving clinical care. Article 6 notes that the physical and psychological integrity of the patient must be safeguarded (11) [italics added].

*The International Code of Medical Ethics* based upon the *Declaration of Geneva* (1947) (12) also notes that any act, or advice which could weaken the physical or mental resistance of a human being may be used only in their interest [italics added].

With regard to public statements, the *Members' Handbook of the British Medical Association* notes that it is not generally permissible for a medical practitioner to publish material on medical subjects elsewhere than in the medical press. No letter, article, or paragraph relating to disease or its treatment, the authorship of which is indicated, should be permitted to appear in the lay press. Exceptions may include *factual* reports of events of public concern (13) [italics added].

These summaries demonstrate the responsibility clinicians have both to the psychological welfare of

patients (equally with their physical welfare), to factual public statement, and to discouraging discrimination. In addition, it is clear that legal encouragement of discrimination is also discouraged. There do exist, then, general principles of human rights and medical ethics which support the argument that psychological and social harm to individuals is as much the concern of the clinician as is physical harm.

At the outset, it must be acknowledged that issues of a psychological or social nature relating to AIDS are as much ideological and political as they are ethical. Skrabanek (14) suggests that issues of preventive medicine have little to do with science, relative risks and risk factors, and could be more profitably debated within the frameworks of ethics, politics and vested interests. He argues that when we aim to prevent suffering rather than reduce it by a positive action of doing good rather than doing no harm, we are expressing a totalitarian ideology in scientific terms. Forcing individuals to live healthy lifestyles, he argues, without also refusing to treat those who continue to harm their health, is inconsistent. The stage is reached where we only accept for treatment those who behave and adhere to the same ideology as ourselves: at this point, morality has corrupted medicine. More subtly, however, Skrabanek's argument may be extended to our *attitudes* toward lifestyles.

This point, however, is precisely the point at which the psychological and social dimensions of ethics in relation to AIDS must be considered. Brandt (15) notes that STDs have become a rallying point for concerns about sexual mores and a more generally perceived social disorder. In short, STDs have become a potent social symbol. Many of the issues which AIDS has raised have nothing to do with the pathogen HIV but a great deal to do with social and ideological viewpoints which are activated by this social symbol. At a clinical level, however, patients are also perceived as being symbolic, and hence the negative reactions cited above to treating homosexual patients. The psychological ethical issue which subsumes most of the more specific ethical issues is whether the potency of AIDS as a social symbol interferes with our psychological management of infected people and with social and medical policies we favour, which are coloured by our attitudes to homosexuality and illicit drug use. Some individuals see premarital or extramarital sex as 'causing' STDs or homosexuality or intravenous drug use as 'causing' AIDS. Psychological approaches to the patient and social approaches to health policy will be coloured by these perceptions and what appear to be clinical or ethical decisions may in fact be ideological ones based on misconceptions. Views of how most appropriately to prevent the spread of AIDS are also often based to a large degree on the social symbolism of AIDS and not on accepted principles of preventive medicine which emphasise the reduction of spread of a pathogen as a primary requirement. This is well illustrated by the laws which have been brought down in some states supposedly to

limit AIDS, despite the existence of broader general laws which already adequately serve that purpose (16). Such laws serve only to promote discrimination and encourage psychological and social harm to those discriminated against.

All preventive and clinical aspects of AIDS have psychosocial implications (17): five points serve to illustrate this. First, most people with AIDS in the Western world are minority group members (18). Second, AIDS has been extensively associated in the public consciousness with blame and punishment. Third, as a result of these first two points, a diagnosis of HIV antibody-positive status will frequently reactivate all the pre-existing negative perceptions an individual has internalised, leading to psychological morbidity of varying degrees. Fourth, social supports are likely to be withdrawn, or to be withheld, as a result of persons being perceived to be at risk for AIDS by behaviour or association. Finally, in the HIV antibody-positive individual, uncertainty over outcome and fears of illness, disability, exposure, and death produce new stresses. Perhaps the best illustration of psychological ethical aspects of AIDS is in the area of patient contact.

### **Ethics and clinical contact**

A duty of care includes a duty of minimising harm produced by that care. The maxim, 'above all, do no harm' may include harm through omission (that is, a failure to treat in some situations would constitute doing harm). This also has public health implications. Given the stresses associated either with diagnosis of HIV antibody-positive status or presentation for testing, adequate information to prevent anxiety or misunderstanding of test significance is critical. So too is adequate information on prevention of viral spread, regardless of whether individuals test positive or negative for HIV antibodies, to minimise possible harm to others. Full details of the meaning of the test, preferably in writing, should be given at the time informed consent is obtained. Negative aspects of testing should also be raised, since social sequelae of testing in some jurisdictions may include notification of name, preclusion from some occupations, and provision of test results to insurers.

In terms of reducing harm to patients, prior to testing, a mental health history should be taken to preclude significant morbidity or mortality if the result proves positive (looking particularly for prior history of depression or suicidal ideation or ego-dystonic states as a result of minority group membership). Even if individuals test negative, presentation for testing with such a history may indicate a need for psychological intervention in other areas. Understanding of the traumata often involved in becoming aware of HIV antibody-positive status should also lead to avoidance of practices which may lead to psychological deterioration, such as encouraging emotional discharge or challenging the patient's denial without providing alternative psychological supports. The

implication contained here, of course, is that individuals will be notified in person of positive results (and preferably all results) and follow-up counselling provided as a matter of course. The practice of sending all results by post without explanation, particularly when the clinic stamp also appears on the outside of the envelope, is improper both in terms of minimisation of distress and any of its sequelae (which may range from transient anxiety to suicide) and in terms of confidentiality. Informing patients of positive results by telephone, as has been reported (19), is also improper if it places the patient at risk.

Moralising, either implicit or explicit, is inappropriate if a medical duty of care is to be fulfilled. Thus clinician's reactions which include comments such as 'In spite of their extreme revulsion for homosexual activity, Christians have an obligation to offer compassionate support...' (20), ranging through to the use of the laden term 'promiscuous' (21), may fuel guilt, self-blame and depression, and as such produce additional distress. They may also lead to less than full disclosure of difficulties which require psychological or medical intervention in the future.

Psychological considerations in giving advice on testing will also have ethical ramifications. Essentially, the patient should be provided with full knowledge of the positive and negative consequences and the meaning of the test. If an adequate assessment has not been made, either encouraging or discouraging the test may, for particular patients, have the opposite effect to that intended. Two examples illustrate this. In some individuals, knowing they are HIV antibody-positive will spur them to avoid infecting others through having only safe sex (which does not result in transfer of body fluids to a partner) or to avoid sharing needles. In others, knowledge of infection may fuel denial or a revenge motive, and lead to quite the opposite reaction. Clearly, a psychological assessment is required prior to testing, and blanket encouragement or discouragement may have implications for spread of the virus.

From the point of reducing transmission of HIV, given that, at present, the virus can only be contained by behavioural methods to prevent spread, brief psychological assessment of individuals prior to testing as well as avoidance of taking rigid pro- or anti-testing positions will have ethical implications at a preventative level. Delinked (anonymous) screening for epidemiological purposes is an exception to this. While prevention of viral spread and other aspects of primary prevention should be considered by all practitioners, it is arguable whether failure to do so is clearly unethical: failure to counsel on prevention might nevertheless be considered bad medical practice.

### **Ethics and the public perception of AIDS**

Ethically, it has always been considered improper to make public pronouncements which imply one has the status of an expert unless one is, and confines oneself to

that field. AIDS has produced a great number of experts, some of greater status and expertise than others. Unfortunately, since AIDS covers areas ranging from molecular biology to social policy, the possibility of being led into areas which are well beyond one's expertise is enormous, particularly given the often aggressive approach of media interviewers. There are some frank abuses of medical status in this regard, such as, for example, a letter from a medical practitioner to a newspaper which suggests that homosexual men can be 'unmade' by surgery (22) (despite over 30 years of unequivocal medical evidence to the contrary) and which implies that being homosexual is the 'cause' of AIDS. The *British Medical Journal* (23) has acknowledged that medical practitioners have no greater authority than anyone else to speak on moral issues, and that AIDS has stimulated a fresh surge of condemnation of homosexuality, on uncertain moralistic grounds: Dickerson (24) notes that some consider AIDS to be 'Divine judgement on loose morals'. Some medical writers have made similar comments such as: 'Does nature punish behaviour that violates the law of nature too much? ... it has even been said that "human kind has kicked nature, nature kicks back with AIDS". There is something in that' (25).

It has already been argued that clinicians must be able to discount their personal feelings and make objective comment on lifestyle-related illnesses, rather than 'judge or stigmatise... in [a] reprehensible way...' (23). The central ethical abuse in public pronouncements which has psychosocial consequences is the assumption that AIDS is 'caused' by homosexuality, intravenous drug use, prostitution, and certain ethnic origins.

The view of HIV infection as 'punishment', according to Kopelman (26), may be evidence of people trying to make a chaotic world 'fit' their idiosyncratic notions of control or justice. The subtle form of this includes the term 'risk group', which according to Ross (27) also provides a metaphor of otherness and a community divided into 'us and them'. While this term is acceptable if used in a strict epidemiological context, it has been used loosely with the implication that members of particular minority groups are a risk as distinct from potentially *being* at risk. The inevitable consequence is the exacerbation of discrimination against groups which are already stigmatised. Far preferable is the term 'at-risk behaviour': a sizeable minority of homosexual men, for example, do not practise sexual behaviours which lead to the risk of transmitting HIV (21), and a sizeable number of intravenous drug users do not share needles. On the other hand, there is good evidence (28) that some men who consider themselves heterosexual may also engage in at-risk behaviours such as unprotected anal or oral intercourse with other males, and may not consider themselves at risk because they do not define what they are doing as 'homosexual'. Psychosocial sequelae are thus increased

discrimination and the mental health consequences this may entail (29) and failure of some individuals (who do not see themselves as being in 'risk groups') to modify behaviour which may infect others.

A tension inherent in rejection of the use of the concept of punishment, is the risk of providing a contradictory message about prevention of transmission of HIV. While it is important to make it clear that HIV is usually transmitted by avoidable actions, it is important to avoid the implication of blame. According to Kopelman (26), we cannot argue that those infected have been irresponsible in their health behaviours since first, while health is a good, it is not the only good and some risks with health may not be irrational or uninformed when judged in terms of other duties or goods. Second, she argues, some education programmes fail to communicate realistically and simplify the associations of risky behaviour and disease, and third, educational programmes presuppose that people can easily alter their behaviour and act responsibly. Not all people, particularly when under the influence of drugs or engaging in a sexual encounter, can do otherwise, intend the act done, or foresee and intend the salient consequences. It is thus important for educational programmes to avoid subtle and unjust ascription of responsibility, since psychological harm may flow from the infected person's self-attribution of blame or punishment. This may (although not inevitably) create some tension between the need to reduce psychological harm and the need to reduce viral spread through clear messages of how to avoid infection.

The second abuse which has relevance because of its psychological effects and which may occur in public statements concerns the attribution of blame or responsibility. Because, at least since 1984 when it was reasonably certain that HIV was the causative agent of AIDS, certain behaviours have been known to place individuals at risk, there is a view that people take chances and must be held responsible for the outcome. This is particularly apparent in the case of the use of the term 'innocent victim' used in the case of AIDS contracted by transfusion of blood or other blood products. The implication is that other victims are guilty, both of the disease of 'innocent victims' and of their own disease. Ross (27) has argued that the language of AIDS has particular ethical ramifications in that public policy, ethical judgements and personal choices can be deeply influenced by the metaphors used. In the case of AIDS, she argues, the metaphors of death, punishment, crime, and war influence the perceptions of those infected with HIV as well as the perceptions of others and their response to those infected. Psychological sequelae of this are twofold: first, the strong impression is generated that AIDS is a punishment for some wrongdoing or for the behaviour that may have resulted in infection. This in turn leads to self-blame, lack of self-esteem, and in some cases may progress to clinical depression associated with devaluation of oneself and one's sexual or other

orientation. This may affect the so-called 'innocent victims' as well: if it is a punishment, what has the 'innocent victim' done to deserve it? For some, this leads to the prejudice that the only certainty is that the disease is a curse visited on many but caused by the sins of a few (30).

Second, and more important from the preventative perspective, the use of the term 'innocent victim' will generate similar feelings in other members of minority groups stigmatised as 'at-risk groups' even if they are at no risk by reason of their behaviour, and may lead to anxiety, hypochondriasis, and of course the effects of increased discrimination. This makes a distinction between justification based on minimising harm to those with HIV infection, and harm to those in so-called 'at risk groups'. Such a justification is based on the need to reduce the overall spread of the disease, with welfare maximisation a second objective. Hirsch and Enlow (31) report that within the gay community, the homophobic response to AIDS is amplified, incorporated into self-perception, and internalised into a negative self-image. Problems arising from this, they note, include decreased ability to achieve intimacy, denial of risk, depression, characterised by self-pity and hopelessness, self-destructive behaviour, and distancing from social supports. These problems may, in fact, lead to *increased* anonymous and risky sexual encounters! Socially imposed homophobia may give rise to loss of jobs, of housing, or of family: such occurrences, which are regularly reported, disrupt the quality of life and may also disrupt psychological and social adjustment. Attribution of blame or responsibility may also lead to restrictive legislation which may have the effect of exacerbating the spread of AIDS (9) and other STDs or discouraging testing or presentation for diagnosis (32). Legislation may thus also lead to discrimination in occupation, housing, and social interaction, all of which will become further life stressors. It should be noted that the psychosocial sequelae described may also occur in the partners and family of individuals who are in so-called 'risk groups' or are infected with HIV.

Negative reactions to homosexual individuals may have been one of the major factors implicated in the epidemic spread of HIV infection in the United States to date. Shilts (33) provides compelling evidence that the Reagan administration ignored the initial spread of HIV for several years because it was perceived to be a disease of gay men, and thus not of concern. This reaction undoubtedly led to a considerably higher infection figure through delays in education and funding, as well as delays in funding research to identify the causal agent. The stigmatised status of homosexual men was clearly a factor in allowing the spread of the epidemic to go unchecked and under-researched for so long, with immense public health implications for the subsequent scale of morbidity and mortality as well as health funding.

The phenomenon of scapegoating is well known in the history of medicine. Examples include the blaming

of ethnic minorities such as the Chinese in Australia for smallpox epidemics in the last century, resulting in loss of life, possessions and livelihood as a result of rioting (caused by prejudice and triggered by blaming the Chinese for the introduction and spread of disease), and later blaming the same group of immigrants for bubonic plague (34), and blaming immigrants to the United States for the lowering of population intelligence scores (35). It is naive to assume that this process is not still occurring, and equally naive to assume that unconsidered statements on AIDS will not be used to create or promote such scapegoating. It is a consistent feature of all examples of attributing blame or responsibility for epidemics throughout history that scapegoating of minority groups occurs. In this context, there is some fairly clear evidence that mental health, in homosexual men at least, is dependent on the perceived societal reaction to their homosexuality (36), and that the result of increasing stigmatisation will almost certainly be translated into a psychological form. Forstein (18) describes the process as producing distress through exacerbating residual internalised self-hatred.

Finally, as a justification for minimising viral spread, attribution of responsibility for infection may also be translated into revenge motives in some patients, for example in seeking to spread the virus further or in attempts at revenge directed against specific individuals or groups of individuals. In some individuals who are at risk and depressed, alcoholic, passively self-destructive or suicidal, spreading AIDS as a means of committing suicide (37) may be promoted or exacerbated by homonegative statements.

Media interest in AIDS may also compound the psychological and social stresses on individuals who are perceived to be at-risk by virtue of their membership in a minority group. Where the media make AIDS a constant issue, the psychosocial pressure is maintained rather than being episodic or transient. Scaremongering in some media may maintain homonegative attitudes and encourage community division. More important from a psychological point of view, however, it may drastically increase community fear of AIDS to an unreasonable level, with marked anxiety of fear of contracting the disease in individuals who are not at risk. Baseless fears about AIDS in the community generally are not uncommon (38) and the irresponsible in some media may frequently promote the view that infection with HIV is an inevitable death-sentence (although estimates vary, suggesting that from 30 per cent upwards of those infected with HIV will progress to the terminal condition). Miller (39) notes in this context that onset of acute anxiety in patients tends to be associated with the appearances of new media headlines about AIDS. On occasions where the media name or expose people with AIDS, the distress caused to the individual, the family and significant others is obvious and needs no elaboration.

In summary, it is thus critical, in terms of public comment, that the psychological effects (which may

include subtle and unintentional insinuations) of comments about AIDS can be seen as contributing, from the level of the individual patient through to the level of public discrimination and scapegoating, to psychosocial distress of a range of types (18, 31). A second central issue is the need to recognise that AIDS has become an opportunity for individuals who have negative attitudes towards sex or homosexuality to justify their attitudes behind a smokescreen of science (40), and this also will add to the psychosocial burden. Even where there is no such intent, Cassens (30) has noted that opinions and statements may well derive from a 'natural attitude' independent of special expertise, and that many will speak beyond the limits of their expertise. Professionals should thus be aware that any comments, clinical or public, may have adverse psychological effects.

### The comparative perspective

If we are to respond to the many psychological issues which arise as a result of AIDS, HIV infection needs to be put back into a comparative perspective. Indeed, many of these difficulties arise because we tend to see AIDS as new, and as a major health threat both to individuals infected with HIV and from a public health perspective. Without in any way denying the undoubtedly serious implications AIDS has at both levels, there are other similar disease processes which have not in the past evoked the same response, such as Hepatitis B virus infection, and Papilloma virus infection. Neither of these invoke quite the same response as AIDS, probably because they are not so readily linked with supposedly deviant sexuality or with clear minority groups (though they may also be less likely to be fatal). Hepatitis B surface antigen is carried by about 0.1 per cent of individuals in Western countries and up to 26 per cent in some ethnic minority groups. Infection may have some sequelae not dissimilar to HIV infection: a (much lower: 1-5 per cent) mortality rate, and a massively increased risk of hepatocellular carcinoma (41, 42). Compared with the AIDS virus, it probably carries around one thousand times more infectious units per cc of blood (43) and is significantly harder to inactivate. Similarly, Human Papilloma Virus is implicated in around 90 per cent of cases of cancer of the cervix (44) and the death rate from invasive cancer of the cervix is currently higher than that from AIDS. However, it must also be noted that HIV infection does appear to have longer term consequences which may be more serious in terms of morbidity and mortality, given that there is no vaccine (as for Hepatitis B) or early treatment (as for cervical dysplasia). All three are major public health threats, one associated with minority groups and the other with sexual transmission, yet the responses to these two infections and AIDS are qualitatively different.

While AIDS is certainly a new and major medical challenge, there is no justification for considering it as importantly different, from a legal, ethical, psychosocial or medical point of view, from other

similar sexually transmissible conditions such as Hepatitis B and Human Papilloma Virus. Higher standards of confidentiality, however, may be justified for AIDS, given the negative psychological consequences which may arise from exposure. Similarly, we must recognise that laws designed to recriminalise homosexual behaviour or to apply penalties to it which we could not justify for similar infections are inappropriate. Because individuals whose behaviours place them most at risk of HIV infection are usually those who have had most to fear from the law in the past, they are less likely to present for screening. Screening is made even more unlikely whether HIV seropositives are reportable or not, if confidentiality cannot be guaranteed. Those who engage in homosexual behaviour or intravenous drug use and who may have put themselves at risk are even less likely to present since their stigmatised minority status is invisible. If there is any risk of exposure involved in presentation, presentation will not occur. Any measures or pronouncements which appear to increase the risk of exposure as homosexual, intravenous drug user, or carrier of a stigmatised disease (AIDS has been referred to as the 'new leprosy') are only going to lead to individuals avoiding testing or diagnosis (mainly to avoid the psychosocial stigma and stressors which may result from this). Thus, laws, regulations and other measures which add to the stigma of either at-risk behaviours or carriage of HIV, are likely to add to the negative perceptions of, and reactions to, such states. Unless it can be demonstrated that such measures have a beneficial effect in controlling transmission of HIV and are not simply unworkable windowdressing for the purposes of appearing to do something, they must also be considered unethical in terms of their potential psychosocial sequelae. Indeed, Black (45) has noted that this simply amounts to public enforcement of private morality. In terms also of the comparative perspective, one must ask whether we would consider similar laws to limit the transmission of Hepatitis B virus or Papilloma Virus to be acceptable. There cannot be one set of civil liberties for one section of the community and another for stigmatised minorities without this adding to (or underscoring) the sense of blame, the guilt, the stresses of actual or anticipated discrimination and the low self-esteem in such individuals.

## Conclusions

The mental health consequences of HIV infection, or fear of infection, when added to the burden already borne by membership of a stigmatised minority group and the need to hide one's identity, are considerable. In fact, the psychosocial morbidity generated by AIDS probably exceeds the medical morbidity associated with the syndrome. It is thus important to consider psychological aspects of our judgements about and behaviours concerning HIV infection, particularly actions which might worsen the psychosocial sequelae

of AIDS-fuelled discrimination or HIV infection, which may do harm to our patients, or which may not prevent the continuing spread of the disease when it is within our power to reduce it.

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## News and notes

### Effectiveness, Efficiency – and Ethics?

A conference on medical ethics, will be held at the University of Warwick on Wednesday 5th July and will run from 9.30 am until 4.30 pm.

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